Sexologies (2013) 22, e55—e58

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ORIGINAL ARTICLE

Postoperative regrets after sex reassignment surgery: A case report☆

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Available online 11 October 2012

KEYWORDS
Transgender;
Postoperative regrets;
Psychology;
Case report;
Gender dysphoria;
Gender identity disorder

Summary
Introduction. — Sex reassignment surgery is carried out in France with the approval of a multidisciplinary team of psychiatrists, psychologists, endocrinologists and surgeons. The specialists monitor the patient for at least 2 years before any irreversible surgical decision concerning the sexual organs is taken.
Objective. — To understand the reasons for regrets after surgery and to review our psychological and psychiatric assessment tools.
Method. — We present here an exceptional case of an individual who wants to return to his birth sex just days after surgery. The individual concerned was born male and was monitored by the team for a period of 8 years before the decision for surgical intervention was taken. We studied the patient's file in detail including the various consultations he had with the psychiatrist of the transgender unit and with the rest of team. We also analyzed the results of psychological tests and the follow-up questionnaire.
Results. — The use of psychological tests did not shed any light on the high risk of postoperative regret in this case. The elements of differential diagnosis were discussed but the patient was untruthful in his answers.
Conclusion. — The scientific literature shows that the risk of regret is higher among men who have experienced a long heterosexual life, whose request for sex reassignment comes late in life, and who do not receive the support of family and friends. To this conclusion, we might add that the lack of sex life, interruption of the treatment and the absence of gender disorder in childhood seem to be significant criteria for risk of postoperative regret. In addition, in our unit, we have abandoned the use of psychological tests to assess the request of transgender patients.

DOI of original article:http://dx.doi.org/10.1016/j.sexol.2012.08.015.
☆ Ce numero inclut également une version française : Karpel, L, Cordier, B. Une demande de retour au sexe de naissance après une chirurgie de réassignation sexuelle.
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1158-1360/$ - see front matter © 2012 Published by Elsevier Masson SAS.
http://dx.doi.org/10.1016/j.sexol.2012.08.014

Psychiatrists take careful precautions before proposing a diagnosis of transgenderism and before any indication of sex reassignment surgery (SRS). Among these precautions specific standards of care have been proposed in France and abroad: psychiatric follow-up over 2 years, real life experience (that is to say, living full-time in the preferred gender role) for at least 1 year and positive results in certain psychological tests: intelligence, personality and projective tests. The purpose of this procedure is to ensure that the patient's request is not the result of acute deliria or other chronic or temporary delusional disorder. Psychological tests are helpful tools for any diagnosis.

They should ideally provide information concerning the nature of the individual's psychological structure, his or her defence mechanisms and identificatory movements. In France, the psychological tests are conducted by clinical psychologists in transgender units.

The case of ''Sanglier''

Born male, after 8 years of follow-up in the psychiatric transgender unit, he underwent SRS according to his desire to become female. Twenty days after the operation, his surgeon received an email from him announcing his desire to undergo revision surgery to reverse back to his original gender. If this was not obtained, he threatened to start drinking again, along with other vague and aggressive threats.

In response to this unusual request, the surgeon asked the patient to meet with the psychiatrist who was in charge of his assessment. The patient did not keep the appointments made for him with neither the surgeon, nor the psychiatrist. He reacted only 6 months later when he was asked to fill in a postoperative well-being survey. In his response, he expressed a mixture of violence and paranoid traits. He rejected a new proposal for a psychiatric consultation after the survey questionnaire was received. He finally saw the surgeon again 1 year after the operation. He wanted to be called ''Mr'', and strongly criticized the result of his surgery. He said that he did not intend to ask for a change of sex in the public registers. However, he asked the surgeon to amputate his female organs (labia, clitoris and vagina). The surgeon refused to do so without prior psychiatric consultation. The patient later met with the psychiatrist in charge of the assessment to whom he explained that he had ''been lying'' during the years that preceded the surgery. He said that his only intention was to get rid of his penis because he saw it as being the source of his sexual impulses (both hetero and homosexual), too invasive for his taste. Since surgery, the patient cut his hair short. He was no longer taking hormones and wanted a mastectomy. The psychiatrist concluded that the patient was suffering from a particular form of body dysmorphic disorder. For the following 6 months, the patient continued to insist on revision surgery, then suddenly broke all contact with the unit.

The anamnesis conducted by the psychiatrist during the assessment period describes an individual feminised by various facial surgeries and hormonal treatments already before his surgery. It also shows that the patient had nor social life nor sexual or romantic relationships. He was no longer professionally active. Previously, he had very masculine professional occupations. He cut all ties with his family. He had been married for 7 years and had several additional female partners but never had any homosexual experiences. He interrupted the assessment procedure of his request for SRS for a period of 3 years. He has no memory of gender identity difficulties as a child. According to the patient, the anti-androgen treatment, which affects the capacity to have erections, provided relief for him. At one point, he admitted he was attracted to men but during the second period of assessment he denied this. The surgery was authorised by a second psychiatrist in the same unit.

After 2 years of follow-up, the patient underwent psychological tests. The vocabulary test showed an average IQ of 95. His average level of intelligence was that of a child at the end of primary education. The WAIS-R showed a verbal IQ of 90 and a performance IQ of 100, hence an average of 95, corroborating the results of the first test. The Benton test showed that the patient was not suffering from any pathology that was distorting his visual, spatial or temporal perceptions. The results of the MMPI-2 personality test show that the test was at the borderline of validity due to the patient's high levels of mistrust and he was prone to lying. He gave different answers to the same questions expressed differently during the test. The results describe an individual who is temperamental and hypersensitive, with risks of brutal acting out. The main defence mechanisms used by the patient are projective and psychopathic. The masculine-feminine scale, scale of sexual stereotypes, shows a great interest in everything related to female stereotypes whilst the male stereotypes were systematically rejected. The result of the projective test (Rorschach) is difficult to analyse. The patient could not always give a representation to the images being shown. Nevertheless, it was concluded that the patient was searching for femininity. The conclusion of the tests was that the patient could be considered a primary transsexual without any severe pathology that would be a contraindication for SRS.

In our opinion, it is not necessary, and is perhaps even unethical, to ask patients consulting for reassignment surgery to sit intelligence tests. What minimum intelligence level should be imposed when assessing a request for sex reassignment? The same problem arises concerning the test to measure a patient's visual, spatial or temporal perceptions. What are the diagnostic elements gained by these tests? As for the MMPI personality test, developed in the USA during the 1950s and revised in France during the 1990s, it seems to rely on very crude stereotypes of masculinity and femininity. It is very easy for a patient to give the anticipated answer corresponding to his case. Anyway, even if the items of the male-female score only represent 10% of the items in this test, their analysis is obsolete, outdated and almost ridiculous considering the fact that the anticipated ''deviances'' do not correspond to modern Western 21st century society, in which equality between men and women has gained ground over the stereotypes of the so-called passive homosexual man and the cold, dominating woman (see the analysis of these items in the textbooks: Hathaway and Mac Kinley, 1989). However, the MMPI remains an interesting test when it comes to revealing the salient features of a subject's personality. As for the use of projective tests like Rorschach, these can be useful in gleaning some elements concerning the patient's identificatory modes, but only if

the patient plays the game and answers truthfully with his own representations of the inkblots shown to him, which was not the case with this patient. The subject did not undergo a TAT test.

A second point for criticism comes from our tendency to be convinced of the eligibility of a patient requesting SRS by their appearance in the desired gender. The problem facing transgender patients is precisely ''not'' one of appearance, contrary to this case. We should not fall into the trap of believing that the patient who uses the best tricks to hide the visible features of his sex of birth is the best candidate for sex reassignment. Some transvestites are much more convincing from an aesthetic point of view than some transsexuals as women, but they are not interested in SRS because at other moments of their lives (when they are not cross-dressing), they feel quite comfortable in their biological gender.

The third criticism concerns the transsexual patients' sexuality. Although each individual has sexual practices specific to himself or to his couple, transsexuals, and more specifically MtF, often have their own specific sexuality. In fact, most of them have experimented with a full homosexual relationship where they systematically play the female role. Often, these patients do not like to be touched or masturbated. They prefer heterosexuals and bisexuals because they are afraid that they might be loved by a homosexual man only for their masculine aspects. They rarely play an active role. Their fantasies revolve around being a woman penetrated by a man. Even in so-called heterosexual activities, the game of cross-dressing is part of the couple's sexuality in which the patient is not very active. In the case of our patient, we know nothing about his sexuality because he kept saying that his sex life was very poor, leading to divorce and separation. He barely admitted to being attracted to men, despite the psychiatrist's best efforts. In our opinion, his sexuality was insufficiently investigated. We are totally lacking information about the quality of his sex life during 7 years of heterosexual marriage. We know nothing of either the reality or the fantasies of his sexuality, both past and present. The patient repeatedly refused to provide this information despite repeated questioning by the psychiatrist.

The fourth criticism pertains to the interruption in the patient's psychiatric follow-up. After a period of 2 years the patient broke all contact, at the point when the psychiatrist asked him to meet with someone from his family, preferably his mother, and at the same time expressed concern about the patient's social and emotional isolation. It was also revealed at this time that the patient had violently acted out (attempt to strangle a work colleague), leading to his dismissal. He was also concerned about the patient's general dissatisfaction with the facial surgery he had previously undergone. The interruptions in the follow-up appear as obvious expressions of doubt, of hesitation and fear on the patient's part.

Conclusion

According to the literature, the potential for postoperative regret is more common among MtF transgender subjects who:

- are older, aged more than 30 when they first request SRS (Eldh et al., 1997; Lindemalm et al., 1987);
- have characterised personality disorders with personal and social instability (Pfallin, 1992; Bodlund and Kullgren, 1996; Lundström and Walinder, 1985);
- lived previously as heterosexuals, with marriage and/or parenthood (Muirhead-Allwood et al., 1999; Pfallin, 1992; Landen et al., 1998);
- are lacking family support (Smith et al., 2005; Landen et al., 1998; Walinder et al., 1978);
- have not suffered from gender identity disorders during childhood (Blanchard et al., 1989; Lindemalm et al., 1987; Pfallin, 1992; Cohen-Kettenis and Van Goozen, 1997);
- are lacking sexual experience with men (Pfallin, 1992);
- are lacking sexual activity (Lindemalm et al., 1987);
- express dissatisfaction with the results of surgery (Lawrence, 2003).

Our patient falls within all of these risk categories. However, after studying this case, we can identify three main risk criteria for postoperative regret in his case:

- the first is the absence of gender identity disorder in childhood. In our opinion, this is one of the most central criteria of our assessment, while taking into account the environment that contributes to or prevents the expression of the disorder. This patient has never cross-dressed in his childhood or during adolescence. He did not suffer from a gender identity disorder. Not only did his desire for SRS arrive late in life but so did the very expression of the gender identity disorder itself;
- the second important criteria in the assessment is the patient's sexuality. This is one of the most essential points. It is crucial that we acquire as much information as possible on the patient's sexual life and we should not be satisfied with claims by the patient that they did not have a sex life. We need to explore the sexual life of the patient in the past and present, considering his or her real, imaginary and fantasy sexuality because we believe that there are patterns of sexuality that are typical to transsexuals;
- the third point concerns the interruptions in the follow-up. The study of this case and of the scientific literature on the matter (Olsson and Möller, 2006) alerts us about this aspect. After any interruption in the follow-up, we must ask ourselves whether this interruption is an expression of a probable doubt, hesitation, uncertainty on the part of the patient. It is, in our opinion, an element that should be added to the list of situations that increase the risk of postoperative regret.

We learn from other researches (Rauchfleish et al., 1998) some other important aspects that should also be taken into account: the psychological observation must continue during at least the first year, and especially acutely close to the surgical procedures. We need to be sure of the patient's emotional stability in order to be able to overcome any disappointments and frustrations associated with the surgical results. We need to ensure the patient's social, family and professional integration before surgery, although this should not constitute grounds for a refusal of SRS.

The study of this case leads us to question our methods of assessing requests for sex reassignment surgeries. The scientific literature had already re-assessed some elements that can potentially lead to postoperative regret. We have highlighted here three fundamental elements. Moreover, the psychologist who meets the patient has to try to understand the specific difficulties and situation of each patient and ask the right questions bearing in mind that each patient's request is different and rarely confined to repeated stereotypes. While excluding social criteria (like age, family, couple life, work), we need to help the patient to project him — or herself into his future encounter with his new body. Psychological tests, in this context, did not seem very helpful in the assessment of risk of postoperative regret. We have therefore decided not to systematically use these tests, but only in cases where there is significant doubt about the patient's psychological status.

Disclosure of interest

The authors declare that they have no conflicts of interest concerning this article.

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